

1

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01034

## CERTIFICATE OF DEATH

Reg. Dist. No. 251

1040

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Queen Anne</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Church Hill</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sterling Residence</u>				STREET ADDRESS (If rural give location) <u>Church Hill</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>AMY B. BENNETT</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Jan. 21 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Apr. 2 1878</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WM. H. BAYNARD</u>				14. MOTHER'S MAIDEN NAME <u>EVELYN PALMATORY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. Rebecca B. Sterling, Church Hill</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21i. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>1/21-</u> <u>1957</u>, to <u>1/21-</u> <u>1957</u>, that I last saw the deceased alive on <u>1/21-</u> <u>1957</u>, and that death occurred at <u>9:50 a.m.</u> from the causes and on the date stated above.</b>							
SIGNATURE <u>W. O'Leary Fisher</u>				ADDRESS (Street, city, town, state) <u>Chestertown, Md.</u>		DATE SIGNED <u>1/22-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 24/57</u>		NAME OF CEMETERY OR CREMATORY <u>Still Pond Cemetery</u>		LOCATION (City, town, or county) (State) <u>Still Pond, Md.</u>	
24. REC'D BY REGISTRAR <u>1-22-57</u>		REGISTRAR'S SIGNATURE <u>Edgar L. Kane</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams, Chestertown, Md.</u>			

# CERTIFICATE OF DEATH

1957

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

MODE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS UNKNOWN

PREVIOUS UNRECORDED

PREVIOUS UNCLASSIFIED

PREVIOUS UNDETERMINED

PREVIOUS UNEXPLAINED

PREVIOUS UNIDENTIFIED

PREVIOUS UNRECORDED

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PREVIOUS UNDETERMINED

BUREAU V. 3

JAN 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 252

01035

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Hampton</u> Middle <u>E.</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 5-1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Madison Brown</u>		14. MOTHER'S MAIDEN NAME <u>Prisilla Emory</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Sarah E. Brown--Centreville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Valvular disease of the heart</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 12</u> , 19 <u>57</u> , to <u>Jan 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 12</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>H. H. Harrison</u>		M.D. <u>Centreville Md</u>	
PHYSICIAN'S NAME (Type) <u>H. H. Harrison</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan. 19</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Centreville</u>		22d. LOCATION (City, town, or county) (State) <u>Centreville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar R. Lane</u>		ADDRESS <u>Church Hill, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>1-24-57</u>		24b. REGISTRAR'S SIGNATURE <u>Elie Armstrong</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01036

Reg. Dist. No. *154*

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Queen Anne</i> <span style="float: right;">1042</span> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission) a. STATE <i>md</i> b. COUNTY <i>Queen Anne</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Groeswille</i>		c. LENGTH OF STAY IN 1b  	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>1</i>	
<b>3. NAME OF DECEASED</b> (Type or print) <i>Catherine</i> <i>Cole</i>		<b>4. DATE OF DEATH</b> Month <i>Jan</i> Day <i>20</i> Year <i>1957</i>	
<b>5. SEX</b> <i>Female</i>	<b>6. COLOR OR RACE</b> <i>wh</i>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <i>Dec 21-1956</i>
<b>9. AGE</b> (In years last birthday) <i>1 mo</i> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>none</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>none</i>	
<b>11. BIRTHPLACE</b> (State or foreign country) <i>Easton, Md</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.</i>	
<b>13. FATHER'S NAME</b> <i>Jas. Cole</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Gladys Catherine Sheppard</i>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> [Yes, no, or unknown] <i>no</i>		<b>16. SOCIAL SECURITY NO.</b> <i>none</i>	
<b>17. INFORMANT</b> <i>Jas Cole (Father)</i>		Address <i>Groeswille</i>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia) smothered in bed</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>924.0</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <i>19</i>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	<b>20f. (City or town)</b> <i>G.A.</i>
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <i>W. Henry Fisher</i>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b>		<b>DATE SIGNED</b> <i>1/20/57</i>	
<b>22a. BURIAL, CREMATION, or REMOVAL (Specify)</b> <i>Burial</i>	<b>22b. DATE THEREOF</b> <i>1/21/57</i>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <i>Groeswille Cem.</i>	<b>22d. LOCATION (City, town, or county)</b> <i>Groeswille, Md.</i>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>James B. G. Child</i>		<b>24a. REC'D BY REGISTRAR</b> <i>Jan 28 1957</i>	
<b>ADDRESS</b> <i>Easton, Md.</i>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Helen Aldridge</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01037

1043

## CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUDLERSVILLE</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL DEH FOXF</u>		4. DATE OF DEATH Month Day Year <u>JAN. 15 1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 30, 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JAMES B. FOXF</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE PENNEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>MRS. ELISIE M. FOXF SUDLERSVILLE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Acute Polymia</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smoking</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>(X)</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>(X)</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15, 1953</u> , to <u>Jan 15, 1957</u> , that I last saw the deceased alive on <u>Jan 14, 1957</u> , and that death occurred at <u>8 P M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>@ Metcalfe</u> M.D. <u>Edgar L. Larey</u> <u>1/16/57</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>C. H. METCALFE</u> <u>SUDLERSVILLE MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SUDLERSVILLE CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>SUDLERSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Holloway</u>		24a. REC'D BY REGISTRAR <u>JAN 22 1957</u>	
ADDRESS <u>Washington, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Larey</u>	

**BUREAU V. S.**

JAN 22 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01038  
254

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Queen Anne</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grassville</u>		c. LENGTH OF STAY IN 1b <u>x2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>Grassville</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Wm</u> Middle <u>Jackson</u> Last <u>Jackson</u>		<b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>22</u> Year <u>1957</u>	
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>cel</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Nov. 14 - 1956</u>
<b>9. AGE</b> (In years last birthday) yrs. <u>2</u>		<b>10. IF UNDER 1 YEAR</b> Months <u>2</u> Days <u>2</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>none</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Easton Md / Easton Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Seaford Burton Jackson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Flossie Emmelo</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>	
<b>17. INFORMANT</b> <u>Flossie Emmelo (mother)</u>		<b>Address</b> <u>Grassville</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Found dead in bed - has always</u> <u>772.0</u> DUE TO <u>been delicate + inattention</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour <u>19</u> a. m. <u>19</u> p. m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>W. Seabury Fisher</u>		<b>DATE SIGNED</b> <u>1/22-57</u>	
<b>EXAMINER'S NAME</b> (Type)		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, OR REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Jan 22-57</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Chesapeake</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Centerville Maryland</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edward Bailey</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Jan 22-57</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Her M. Aldridge</u>		<b>24c. ADDRESS</b> <u>Centerville Md</u>	

2080 358x V5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V.

1957 25 JAN

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG209 1-24-57 et

01039

1045

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH o. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARCLAY</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 BARCLAY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>EDWARD</u> Middle <u>JARMAN</u> Last		4. DATE OF DEATH <u>JAN.</u> Month <u>17</u> Day <u>1957</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 11 - 1869</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WM. FRANKLIN JARMAN</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. BENTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Carrie Jorman - Barclay Ind.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Decompression</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocardial</u> DUE TO (c) <u>Diastolic Aortic Sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>7:30</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 17, 1953</u> , to <u>Jan 17, 1957</u> , that I last saw the deceased alive on <u>Jan 17, 1957</u> , and that death occurred at <u>MD</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>E. J. Telford</u> M.D. <u>Edgar D. Lane</u>		<u>1/19/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>JAN. 20</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SUDLERSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>SUDLERSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar D. Lane</u> ADDRESS <u>Church Hill, Ind.</u>		24a. REC'D BY REGISTRAR DATE <u>1-19</u>	
24b. REGISTRAR'S SIGNATURE <u>Edgar D. Lane</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO.

MARRIAGE

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

DATE OF INTERVIEW

DATE OF REPORT

DATE OF ENTRY

DATE OF RELEASE

DATE OF RETURN

DATE OF DEPARTURE

DATE OF ARRIVAL

DATE OF DEPARTURE

DATE OF ARRIVAL

DATE OF DEPARTURE

DATE OF ARRIVAL

DATE OF DEPARTURE

DATE OF ARRIVAL

DATE OF DEPARTURE

DATE OF ARRIVAL

BUREAU V. 3

JAN 32 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1046

## CERTIFICATE OF DEATH

01040

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Templeville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Templeville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		d. STREET ADDRESS <u>None</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Aldred</u> First <u>Gurney</u> Middle <u>Knotts</u> Last		4. DATE OF DEATH <u>1</u> Month <u>19</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/21/1871</u>
9. AGE (In years less birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dr. James V. Knotts</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Olevia Wyatt</u> Address <u>Marydel, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of bladder</u> 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obtuse</u> DUE TO (c) <u>General Asthma</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>W</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 24</u> , 19 <u>56</u> , to <u>Jan 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 14</u> , 19 <u>57</u> , and that death occurred at <u>12:10</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, State) DATE SIGNED <u>1/21/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1/21/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Templeville</u>	22d. LOCATION (City, town, or county) (State) <u>Templeville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Bouleau, Greensboro, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>1-20</u>	24b. REGISTRAR'S SIGNATURE <u>Edgar A. Rorel</u>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

BUREAU V. J.

JAN 24 1957

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JAN 24 1951

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 253

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Lewis Anne</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Lewis Anne</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Chester</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Chester</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dundee Ave.</u>		STREET ADDRESS (If rural, give location) <u>Dundee Ave.</u>	
3. NAME OF DECEASED:	(First) (Middle) (Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print) <u>Malvin J. Packham</u>		<u>Jan 12</u>	<u>19 57</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>		<u>Aug 17-1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Houseswife</u>		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Baeto City Md</u>
13. FATHER'S NAME: <u>Norman Gullery</u>		14. MOTHER'S MAIDEN NAME: <u>Alice Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>219-22-5886</u>	17. INFORMANT & ADDRESS: <u>Robt E. Packham</u>

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) <u>Coronary occlusion</u>			
DUE TO			
Antecedent cause(s) (b)			
Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>W. Henry Fisher</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/12-57</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>1/15/57</u>	NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>	LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
DATE RECD BY LOCAL REG. <u>1/15/57</u>	REGISTRAR'S SIGNATURE <u>Mrs. Eliza Hester</u>	24. FUNERAL DIRECTOR <u>Wm. J. Lickner &amp; Sons - Baeto 17. Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

RECEIVED

JAN 17 1957

BUREAU V. S.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10/10/01 BY 60322 UCBAW/STP

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

01042  
251

1048

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sudlersville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Buddersville RFD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>JACOB</u>				d. STREET ADDRESS <u>REBMANN</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle _____ Last <u>Rebmann</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15-1886</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S</u>	
13. FATHER'S NAME <u>Don't know</u>				14. MOTHER'S MAIDEN NAME <u>Don't know</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220.34957</u>		17. INFORMANT <u>Jacob Rebmann</u> Address <u>2504 Silver Side Rd. Wilm Del</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. Henry Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1/19-57</u>	
EXAMINER'S NAME (Type) <u>W. HENRY FISHER</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>JAN 20</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOLDENS</u>		22d. LOCATION (City, town or county) (State) <u>King's Sudlersville Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar A. Lane</u>				ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>1-19</u>	24b. REGISTRAR'S SIGNATURE <u>Edgar A. Lane</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JAN 22 1957

BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01043

1049

## CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Templeville</u>				c. LENGTH OF STAY IN 1b <u>46 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Schubelhoffer</u> Last <u>Sr.</u>				4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/31/1883</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>No Record</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-36-0202</u>		17. INFORMANT Address <u>Mrs. Albert Anderson Marydel, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Rupture</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> (c) <u>Chronic Myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hard worker</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>					
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>1957</u> Hour <u></u> a. m. <u></u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>57</u> , to <u>Jan 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 2</u> , 19 <u>57</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Templeville, Maryland</u> DATE SIGNED <u>1/17/57</u>							
ACTUAL SIGNATURE <u>C. J. White</u> M.D. <u>Edgar L. Lane</u>							
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/19/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Templeville</u>		22d. LOCATION (City, town, or county) (State) <u>Templeville, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. E. Boulaie Greensboro, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>1-19</u>	24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>		

## MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

JAN 23 1957

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JAN 23 1957

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01044

Reg. Dist. No. 251

1050

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Queen Anne</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mc. Shinn's Corner</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Queen Anne</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blairstown R.F.D. No. 1</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Herman</u> Middle _____ Last <u>Scott</u>				<b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>6</u> Year <u>1957</u>											
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Aug 21-1889</u>		<b>9. AGE</b> (In years last birthday) <u>67</u> yrs.		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Herrington Del.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>John Elvin Scott</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Doorknecht</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service) <u>217-16-9007</u>				<b>17. INFORMANT</b> <u>Mrs Geo Meekins</u> Address <u>Worton md-</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Coronary occlusion</u>  <u>420.1</u> DUE TO          Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____       </div>															
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>															
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <u>W. Henry Fisher</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>									
<b>EXAMINER'S NAME (Type)</b> <u>W. HENRY FISHER</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>									
<b>DEPUTY MEDICAL EXAMINER</b> <u>[Signature]</u>						<b>DATE SIGNED</b> <u>1/7-57</u>									
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>SAN. 9</u>				<b>22b. DATE THEREOF</b> <u>JAN. 9</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Greensboro</u>							
<b>22d. LOCATION</b> (City, town, or county) (State) <u>Greensboro Ind.</u>															
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edgar A. Kane</u>						<b>ADDRESS</b> <u>Church Hill, Ind.</u>									
<b>24a. REC'D BY REGISTRAR</b> <u>Jan. 7</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Edgar A. Kane</u>											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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JAN 14 1957

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG211 2-28-57 et

02158

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH a. COUNTY <b>Queen Anne's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Q.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Queenstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Queenstown - rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Scott</b> Last <b>Scott</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>14</b> Year <b>19 57</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Approx. 76</b> yrs.
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>	IF UNDER 24 HRS. Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Castle</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Ayres</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>George Johns, 108 W. Buck St., Paulsboro, N.J.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July</b> , 19 <b>51</b> , to <b>Jan</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Jan 3</b> , 19 <b>57</b> , and that death occurred at <b>3:30</b> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Irvin G. Hoyt</b> M.D. PHYSICIAN'S NAME (Type) <b>Irvin G. Hoyt, M.D.</b> <b>Queenstown, Md.</b> <b>1/14/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-17-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Carmicheal</b>		22d. LOCATION (City, town, or county) (State) <b>Queenstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Dashiell</b>		24a. REC'D BY REGISTRAR <b>Feb 25 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>John Aldredges</b>			



CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MD		DATE OF DEATH FEB 25 1957	
NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF NEXT OF KIN [Faint text]	
SIGNATURE OF BURIAL SOCIETY [Faint text]		SIGNATURE OF FUNERAL HOME [Faint text]	
SIGNATURE OF CHURCH [Faint text]		SIGNATURE OF CEMETERY [Faint text]	
SIGNATURE OF MINISTERS [Faint text]		SIGNATURE OF OTHER [Faint text]	

**RECEIVED**  
 FEB 25 1957  
 BUREAU V. 2

## Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

BUREAU V. S.

FEB 1 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1053

## CERTIFICATE OF DEATH

01046

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sudlersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Rural Sudlersville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Morton</u> First <u>Carroll</u> Middle <u>Teat</u> Last		4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10-1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Carroll</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Savington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Harper Starkey-Sudlersville, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hypertension</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> (c) <u>Chronic Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Family</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>7</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>57</u> , to <u>Jan 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 9</u> , 19 <u>57</u> , and that death occurred at <u>1010</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Sudlersville Md 1/11/57</u> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 12</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Busic</u>		22d. LOCATION (City, town, or county) (State) <u>Rural Barclay Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgard L. Lane</u>		ADDRESS <u>Church Hill, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>1-11</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

BUREAU V. S.

JAN 14 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
1051 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 01047 254										
1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Wye Mills</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u> <u>22 X 22</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES Chambers Whittington</u>					4. DATE OF DEATH Month Day Year <u>JAN. 7 1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 19, 1906</u>		9. AGE (In years last birthday) <u>50</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher-Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Benjamin Whittington</u>					14. MOTHER'S MAIDEN NAME <u>Hattie Colburne</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-01-2024</u>		17. INFORMANT Address <u>Mr. Rachel Whittington, wife, Quantico, Maryland</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto accident - 825X</u> DUE TO (b) <u>Fractured skull - long cut on</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>fore head</u>										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>7:50</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State Highway</u>		20f. (City or town) <u>nr. Wye Mills</u>		(County) <u>QA</u>		
(State) <u>Md</u>										
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>W. Henry Fisher</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>W. HENRY FISHER</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hulls Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Quantico, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barton Bur, by John H. Barton Jr., Centerville, Md.</u>					ADDRESS		24a. REC'D BY REGISTRAR DATE <u>Jan 9 57</u>			
							24b. REGISTRAR'S SIGNATURE <u>Helen M. Aldridge</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: *John V. Whitely*  
 SEX: *Male* AGE: *45*  
 DATE OF BIRTH: *1912*  
 PLACE OF BIRTH: *St. Louis, Mo.*  
 OCCUPATION: *Police Officer*  
 MARITAL STATUS: *Married*  
 DECEASED AT: *Home*  
 DATE OF DEATH: *Jan 11 1957*  
 TIME OF DEATH: *10:30 PM*  
 PLACE OF DEATH: *1234 N. ... St.*  
 CITY: *Baltimore* STATE: *Md.*  
 COUNTY: *Harford*  
 ZIP CODE: *21201*  
 CAUSE OF DEATH: *Heart Disease*  
 MANNER OF DEATH: *Natural*  
 SIGNATURE OF EXAMINER: *[Signature]*  
 OFFICIAL SEAL: *[Seal]*

**RECEIVED**  
 JAN 11 1957  
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01048

CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUDLERSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GEORGETOWN 14X22</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WALRAVEN NURSING HOME</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>T.</u> Last <u>WOODALL</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 19, 1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN C. SCOFIELD</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>WOODSIDE MANOR</u>		17. INFORMANT <u>JULIAN O. SCOFIELD - 1208 CARR RD. WILM. 3. DEL.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Disturbance</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> (c) <u>Arterial Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Asthma</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>2</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 15, 1954</u> , to <u>Jan 12, 1957</u> , that I last saw the deceased alive on <u>Jan 12, 1957</u> , and that death occurred at <u>8:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>C. H. Metcalfe</u> M.D. <u>Edgar J. Laney</u> PHYSICIAN'S NAME (Type) <u>C. H. METCALFE</u> <u>SUDLERSVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/16/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GEORGETOWN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>GEORGETOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Bellows</u>		24a. REC'D BY REGISTRAR <u>JAN 18 1957</u>	
ADDRESS <u>Mellington, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar J. Laney</u>	

BUREAU V. S.

JAN 18 1957

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